Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence.

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. 54 p. (Clinical guideline; no. 115).

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Principles of Care

Building a Trusting Relationship and Providing Information

When working with people who misuse alcohol:

- Build a trusting relationship and work in a supportive, empathic and non-judgmental manner.
- Take into account that stigma and discrimination are often associated with alcohol misuse and that minimising the problem may be part of the service user's presentation.
- Make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected.

When working with people who misuse alcohol:

- Provide information appropriate to their level of understanding about the nature and treatment of alcohol misuse to support choice from a range of evidence-based treatments.
- Avoid clinical language without explanation.
- Make sure that comprehensive written information is available in an appropriate language or, for those who cannot use written text, in an accessible format.
- Provide independent interpreters (that is, someone who is not known to the service user) if needed.

Working with and Supporting Families and Carers

Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change.

When families and carers are involved in supporting a person who misuses alcohol, discuss concerns about the impact of alcohol misuse on themselves and other family members, and:

- Provide written and verbal information on alcohol misuse and its management, including how families and carers can support the service user.
- Offer a carer's assessment where necessary.
- Negotiate with the service user and their family or carer about the family or carer's involvement in their care and the sharing of information; make sure the service user's, family's and carer's right to confidentiality is respected.

When the needs of families and carers of people who misuse alcohol have been identified:

- Offer guided self-help, usually consisting of a single session, with the provision of written materials.
- Provide information about, and facilitate contact with, support groups (such as self-help groups specifically focused on addressing the needs of families and carers).

If the families and carers of people who misuse alcohol have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems, consider offering family meetings. These should:

- Provide information and education about alcohol misuse
- Help to identify sources of stress related to alcohol misuse
- Explore and promote effective coping behaviours
- Usually consist of at least five weekly sessions

All staff in contact with parents who misuse alcohol and who have care of or regular contact with their children, should:

- Take account of the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network
- Be aware of and comply with the requirements of the Children Act (2004)

Identification and Assessment

General Principles

Make sure that assessment of risk is part of any assessment, that it informs the development of the overall care plan, and that it covers risk to self (including unplanned withdrawal, suicidality and neglect) and risk to others.

Staff working in services provided and funded by the National Health Service (NHS) who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if

they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

When conducting an initial assessment, as well as assessing alcohol misuse, the severity of dependence and risk, consider the:

- Extent of any associated health and social problems
- Need for assisted alcohol withdrawal

Use formal assessment tools to assess the nature and severity of alcohol misuse, including the:

- Alcohol Use Disorders Identification Test (AUDIT) for identification and as a routine outcome measure
- Severity of Alcohol Dependence Questionnaire (SADQ) or Leeds Dependence Questionnaire (LDQ) for severity of dependence
- Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar) for severity of withdrawal
- Alcohol Problems Questionnaire (APQ) for the nature and extent of the problems arising from alcohol misuse.

When assessing the severity of alcohol dependence and determining the need for assisted withdrawal, adjust the criteria for women, older people, children and young people (see recommendation below for assessment of children and young people), and people with established liver disease who may have problems with the metabolism of alcohol.

Staff responsible for assessing and managing assisted alcohol withdrawal (see recommendation below) should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and the use of drug regimens appropriate to the settings (for example, inpatient or community) in which the withdrawal is managed.

Staff treating people with alcohol dependence presenting with an acute unplanned alcohol withdrawal should refer to the NICE guideline Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (NICE clinical guideline 100).

Assessment in Specialist Alcohol Services

Treatment Goals

In the initial assessment in specialist alcohol services of all people who misuse alcohol, agree the goal of treatment with the service user. Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity (for example, depression or alcohol-related liver disease). When a service user prefers a goal of moderation but there are considerable risks, advise strongly that abstinence is most appropriate, but do not refuse treatment to service users who do not agree to a goal of abstinence.

For harmful drinking or mild dependence, without significant comorbidity, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence.

For people with severe alcohol dependence, or those who misuse alcohol and have significant psychiatric or physical comorbidity, but who are unwilling to consider a goal of abstinence or engage in structured treatment, consider a harm reduction programme of care. However, ultimately the service user should be encouraged to aim for a goal of abstinence.

When developing treatment goals, consider that some people who misuse alcohol may be required to abstain from alcohol as part of a court order or sentence.

Brief Triage Assessment

All adults who misuse alcohol who are referred to specialist alcohol services should have a brief triage assessment to assess:

- The pattern and severity of the alcohol misuse (using AUDIT) and severity of dependence (using SADQ)
- The need for urgent treatment including assisted withdrawal
- Any associated risks to self or others
- The presence of any comorbidities or other factors that may need further specialist assessment or intervention

Agree the initial treatment plan, taking into account the service user's preferences and outcomes of any previous treatment.

Comprehensive Assessment

Consider a comprehensive assessment for all adults referred to specialist alcohol services who score more than 15 on the AUDIT. A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools (see recommendation above), and cover the following areas:

- Alcohol use, including:
  - Consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
  - Dependence (using, for example, SADQ or LDQ)
  - Alcohol-related problems (using, for example, APQ)
- Other drug misuse, including over-the-counter medication
- Physical health problems
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change

Assess comorbid mental health problems as part of any comprehensive assessment, and throughout care for the alcohol misuse, because many comorbid problems (though not all) will improve with treatment for alcohol misuse. Use the assessment of comorbid mental health problems to inform the development of the overall care plan.

For service users whose comorbid mental health problems do not significantly improve after abstinence from alcohol (typically after 3–4 weeks), consider providing or referring for specific treatment (see the relevant NICE guideline for the particular disorder).

Consider measuring breath alcohol as part of the management of assisted withdrawal. However, breath alcohol should not usually be measured for routine assessment and monitoring in alcohol treatment programmes.

Consider blood tests to help identify physical health needs, but do not use blood tests routinely for the identification and diagnosis of alcohol use disorders.

Consider brief measures of cognitive functioning (for example, MMSE) to help with treatment planning. Formal measures of cognitive functioning should usually only be performed if impairment persists after a period of abstinence or a significant reduction in alcohol intake.

Interventions for Alcohol Misuse

General Principles for All Interventions

For all people who misuse alcohol, carry out a motivational intervention as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including:

- Helping people to recognise problems or potential problems related to their drinking
- Helping to resolve ambivalence and encourage positive change and belief in the ability to change
- Adopting a persuasive and supportive rather than an argumentative and confrontational position

For all people who misuse alcohol, offer interventions to promote abstinence or moderate drinking as appropriate (see recommendations above) and prevent relapse, in community-based settings.

Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:

- Very limited social support (for example, they are living alone or have very little contact with family or friends) or
- Complex physical or psychiatric comorbidities or
- Not responded to initial community-based interventions (see recommendation above)

For people with alcohol dependence who are homeless, consider offering residential rehabilitation for a maximum of 3 months. Help the service user find stable accommodation before discharge.

All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff (if a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented). Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:

- Receive regular supervision from individuals competent in both the intervention and supervision
- Routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment

- Engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate

All interventions for people who misuse alcohol should be the subject of routine outcome monitoring. This should be used to inform decisions about continuation of both psychological and pharmacological treatments. If there are signs of deterioration or no indications of improvement, consider stopping the current treatment and review the care plan.

For all people seeking help for alcohol misuse:

- Give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and
- Help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend

Care Coordination and Case Management

Care coordination is the routine coordination by any staff involved in the care and treatment of a person who misuses alcohol. Case management is a more intensive process concerned with delivering all aspects of care, including assessment, treatment, monitoring and follow-up.

Care coordination should be part of the routine care of all service users in specialist alcohol services and should:

- Be provided throughout the whole period of care, including aftercare
- Be delivered by appropriately trained and competent staff working in specialist alcohol services
- Include the coordination of assessment, interventions and monitoring of progress, and coordination with other agencies

Consider case management to increase engagement in treatment for people who have moderate to severe alcohol dependence and who are considered at risk of dropping out of treatment or who have a previous history of poor engagement. If case management is provided it should be throughout the whole period of care, including aftercare.

Case management should be delivered in the context of Tier 3 interventions by staff who take responsibility for the overall coordination of care and should include:

- A comprehensive assessment of needs
- Development of an individualised care plan in collaboration with the service user and relevant others (including families and carers and other staff involved in the service user's care)
- Coordination of the care plan to deliver a seamless multiagency and integrated care pathway and maximisation of engagement, including the use of motivational interviewing approaches
- Monitoring of the impact of interventions and revision of the care plan when necessary

Interventions for Harmful Drinking and Mild Alcohol Dependence

For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

For harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, offer behavioural couples therapy.

For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider offering acamprosate (note that the evidence for acamprosate in the treatment of harmful drinkers and people who are mildly alcohol dependent is less robust than that for naltrexone. At the time of publication [February 2011], acamprosate did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) or oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) or behavioural couples therapy (see recommendation below for pharmacological interventions).

Delivering Psychological Interventions

Cognitive behavioural therapies focused on alcohol-related problems should usually consist of one 60-minute session per week for 12 weeks.

Behavioural therapies focused on alcohol-related problems should usually consist of one 60-minute session per week for 12 weeks.

Social network and environment-based therapies focused on alcohol-related problems should usually consist of eight 50-minute sessions over 12 weeks.

Behavioural couples therapy should be focused on alcohol-related problems and their impact on relationships. It should aim for abstinence, or a level of drinking predetermined and agreed by the therapist and the service user to be reasonable and safe. It should usually consist of one 60-minute session per week for 12 weeks.

Assessment and Interventions for Assisted Alcohol Withdrawal

See "Special Considerations for Children and Young People Who Misuse Alcohol" below for assessment for assisted withdrawal in children and young people.

For service users who typically drink over 15 units of alcohol per day and/or who score 20 or more on the AUDIT, consider offering:

- An assessment for and delivery of a community-based assisted withdrawal, or
- Assessment and management in specialist alcohol services if there are safety concerns (see recommendation below) about a community-based assisted withdrawal

Service users who need assisted withdrawal should usually be offered a community-based programme, which should vary in intensity according to the severity of the dependence, available social support and the presence of comorbidities.

- For people with mild to moderate dependence, offer an outpatient-based assisted withdrawal programme in which contact between staff and the service user averages 2–4 meetings per week over the first week.
- For people with mild to moderate dependence and complex needs (for example, psychiatric comorbidity, poor social support or homelessness), or severe dependence, offer an intensive community programme following assisted withdrawal in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period

Outpatient-based community assisted withdrawal programmes should consist of a drug regimen (see recommendation below) and psychosocial support including motivational interviewing (see recommendation above).

Intensive community programmes following assisted withdrawal should consist of a drug regimen (see "Interventions for Moderate and Severe Alcohol Dependence After Successful Withdrawal" below) supported by psychological interventions including individual treatments (see "Interventions for Moderate and Severe Alcohol Dependence After Successful Withdrawal" below), group treatments, psychoeducational interventions, help to attend self-help groups, family and carer support and involvement, and case management (see recommendation above).

Consider inpatient or residential assisted withdrawal if a service user meets one or more of the following criteria. They:

- Drink over 30 units of alcohol per day
- Have a score of more than 30 on the SADQ
- Have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
- Need concurrent withdrawal from alcohol and benzodiazepines
- Regularly drink between 15 and 20 units of alcohol per day and have:
    - Significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or
    - A significant learning disability or cognitive impairment

Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.

Drug Regimens for Assisted Withdrawal

When conducting community-based assisted withdrawal programmes, use fixed-dose medication regimens (a fixed-dose regimen involves starting treatment with a standard dose, not defined by the level of alcohol withdrawal, and reducing the dose to zero over 7–10 days according to a standard protocol).

Fixed-dose or symptom-triggered medication regimens (a symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications. The service user is monitored on a regular basis and pharmacotherapy only continues as long as the service user is showing withdrawal symptoms) can be used in assisted withdrawal programmes in inpatient or residential settings. If a symptom-

triggered regimen is used, all staff should be competent in monitoring symptoms effectively and the unit should have sufficient resources to allow them to do so frequently and safely.

Prescribe and administer medication for assisted withdrawal within a standard clinical protocol. The preferred medication for assisted withdrawal is a benzodiazepine (chlordiazepoxide or diazepam).

In a fixed-dose regimen, titrate the initial dose of medication to the severity of alcohol dependence and/or regular daily level of alcohol consumption. In severe alcohol dependence higher doses will be required to adequately control withdrawal and should be prescribed according to the Summary of Product Characteristics (SPC). Make sure there is adequate supervision if high doses are administered. Gradually reduce the dose of the benzodiazepine over 7 to 10 days to avoid alcohol withdrawal recurring.

When managing alcohol withdrawal in the community, avoid giving people who misuse alcohol large quantities of medication to take home to prevent overdose or diversion (when the drug is being taken by someone other than for whom it was prescribed). Prescribe for installment dispensing, with no more than 2 days' medication supplied at any time.

In a community-based assisted withdrawal programme, monitor the service user every other day during assisted withdrawal. A family member or carer should preferably oversee the administration of medication. Adjust the dose if severe withdrawal symptoms or over-sedation occur.

Do not offer clomethiazole for community-based assisted withdrawal because of the risk of overdose and misuse.

For service users having assisted withdrawal, particularly those who are more severely alcohol dependent or those undergoing a symptom-triggered regimen, consider using a formal measure of withdrawal symptoms such as the CIWA-Ar.

Be aware that benzodiazepine doses may need to be reduced for children and young people (at the time of publication [February 2011], benzodiazepines did not have UK marketing authorisation for use in children and young people under 18. Informed consent should be obtained and documented), older people, and people with liver impairment (see recommendation below).

If benzodiazepines are used for people with liver impairment, consider one requiring limited liver metabolism (for example, lorazepam); start with a reduced dose and monitor liver function carefully. Avoid using benzodiazepines for people with severe liver impairment.

When managing withdrawal from co-existing benzodiazepine and alcohol dependence increase the dose of benzodiazepine medication used for withdrawal. Calculate the initial daily dose based on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine (at the time of publication [February 2011], benzodiazepines did not have UK marketing authorisation for this indication or for use in children and young people under 18. Informed consent should be obtained and documented. This should be done in line with normal standards of care for patients who may lack capacity [see www.publicguardian.gov.uk or www.wales.nhs.uk/consent] or in line with normal standards in emergency care). This is best managed with one benzodiazepine (chlordiazepoxide or diazepam) rather than multiple benzodiazepines. Inpatient withdrawal regimens should last for 2 to 3 weeks or longer, depending on the severity of co-existing benzodiazepine dependence. When withdrawal is managed in the community, and/or where there is a high level of benzodiazepine dependence, the regimen should last for longer than 3 weeks, tailored to the service user's symptoms and discomfort.

For managing unplanned acute alcohol withdrawal and complications including delirium tremens and withdrawal-related seizures, refer to NICE clinical guideline 100 (see the NICE guideline Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications).

Interventions for Moderate and Severe Alcohol Dependence After Successful Withdrawal

After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse (see "Interventions for Harmful Drinking and Mild Alcohol Dependence" above).

After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) in combination with behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment (see "Interventions for Harmful Drinking and Mild Alcohol Dependence" above).

After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering disulfiram (all prescribers should consult the SPC for a full description of the contraindications and the special considerations of the use of disulfiram) in combination with a psychological intervention to service users who:

- Have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable, or
- Prefer disulfiram and understand the relative risks of taking the drug (see recommendation below)

Delivering Pharmacological Interventions

Before starting treatment with acamprosate, oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) or disulfiram, conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transferase [GGT]). In particular, consider any contraindications or cautions (see the SPC), and discuss these with the service user.

Acamprosate

If using acamprosate, start treatment as soon as possible after assisted withdrawal. Usually prescribe at a dose of 1998 mg (666 mg three times a day) unless the service user weighs less than 60 kg, and then a maximum of 1332 mg should be prescribed per day. Acamprosate should:

- Usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it (at the time of publication [February 2011], acamprosate did not have UK marketing authorisation for use longer than 12 months. Informed consent should be obtained and documented)
- Be stopped if drinking persists 4–6 weeks after starting the drug.

Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

Naltrexone

If using oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented), start treatment after assisted withdrawal. Start prescribing at a dose of 25 mg per day and aim for a maintenance dose of 50 mg per day. Draw the service user's attention to the information card that is issued with oral naltrexone about its impact on opioid-based analgesics. Oral naltrexone should:

- Usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it
- Be stopped if drinking persists 4–6 weeks after starting the drug

Service users taking oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them for older people, for people with obesity, for monitoring recovery of liver function and as a motivational aid for service users to show improvement. If the service user feels unwell advise them to stop the oral naltrexone immediately.

Disulfiram

If using disulfiram, start treatment at least 24 hours after the last alcoholic drink consumed. Usually prescribe at a dose of 200 mg per day. For service users who continue to drink, if a dose of 200 mg (taken regularly for at least 1 week) does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dose in consultation with the service user.

Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment. Check the SPC for warnings and contraindications in pregnancy and in the following conditions: a history of severe mental illness, stroke, heart disease or hypertension.

Make sure that service users taking disulfiram:

- Stay under supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months
- If possible, have a family member or carer, who is properly informed about the use of disulfiram, oversee the administration of the drug
- Are medically monitored at least every 6 months after the initial 6 months of treatment and monitoring

Warn service users taking disulfiram, and their families and carers, about:

- The interaction between disulfiram and alcohol (which may also be found in food, perfume, aerosol sprays and so on), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse

- The rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

Drugs Not to Be Routinely Used for the Treatment of Alcohol Misuse

Do not use antidepressants (including selective serotonin reuptake inhibitors [SSRIs]) routinely for the treatment of alcohol misuse alone.

Do not use gammahydroxybutyrate (GHB) for the treatment of alcohol misuse.

Benzodiazepines should only be used for managing alcohol withdrawal and not as ongoing treatment for alcohol dependence.

Special Considerations for Children and Young People Who Misuse Alcohol

Assessment and Referral of Children and Young People

If alcohol misuse is identified as a potential problem, with potential physical, psychological, educational or social consequences, in children and young people aged 10–17 years, conduct an initial brief assessment to assess:

- The duration and severity of the alcohol misuse (the standard adult threshold on the AUDIT for referral and intervention should be lowered for young people aged 10–16 years because of the more harmful effects of a given level of alcohol consumption in this population)
- Any associated health and social problems
- The potential need for assisted withdrawal

Refer all children and young people aged 10–15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment of their needs, if their alcohol misuse is associated with physical, psychological, educational and social problems and/or comorbid drug misuse.

When considering referral to CAMHS for young people aged 16–17 years who misuse alcohol, use the same referral criteria as for adults (see 'Assessment in Specialist Alcohol Services' above).

A comprehensive assessment for children and young people (supported if possible by additional information from a parent or carer) should assess multiple areas of need, be structured around a clinical interview using a validated clinical tool (such as the Adolescent Diagnostic Interview [ADI] or the Teen Addiction Severity Index [T-ASI]), and cover the following areas:

- Consumption, dependence features and patterns of drinking
- Comorbid substance misuse (consumption and dependence features) and associated problems
- Mental and physical health problems
- Peer relationships and social and family functioning
- Developmental and cognitive needs, and educational attainment and attendance
- History of abuse and trauma
- Risk to self and others
- Readiness to change and belief in the ability to change
- Obtaining consent to treatment
- Developing a care plan and risk management plan

Assisted Withdrawal in Children and Young People

Offer inpatient care to children and young people aged 10–17 years who need assisted withdrawal.

Base assisted withdrawal for children and young people aged 10–17 years on the recommendations for adults (see 'Drug Regimens for Assisted Withdrawal' above) and in NICE clinical guideline 100 (Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications). Consult the SPC and adjust drug regimens to take account of age, height and body mass, and stage of development of the child or young person (if a drug does not have UK marketing authorisation for use in children and young people under 18, informed consent should be obtained and documented).

Promoting Abstinence and Preventing Relapse in Children and Young People

For all children and young people aged 10–17 years who misuse alcohol, the goal of treatment should usually be abstinence in the first instance.

For children and young people aged 10–17 years who misuse alcohol offer:

- Individual cognitive behavioural therapy for those with limited comorbidities and good social support
- Multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support

After a careful review of the risks and benefits, specialists may consider offering acamprosate (at the time of publication [February 2011], acamprosate did not have UK marketing authorisation for this indication or for use in children and young people under 18. Informed consent should be obtained and documented) or oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication or for use in children and young people under 18. Informed consent should be obtained and documented) in combination with cognitive behavioural therapy to young people aged 16 and 17 years who have not engaged with or benefited from a multicomponent treatment programme.

Delivering Psychological and Psychosocial Interventions for Children and Young People

Multidimensional family therapy should usually consist of 12–15 family-focused structured treatment sessions over 12 weeks. There should be a strong emphasis on care coordination and, if necessary, crisis management. As well as family sessions, individual interventions may be provided for both the child or young person and the parents. The intervention should aim to improve:

- Alcohol and drug misuse
- The child or young person's educational and social behaviour
- Parental well-being and parenting skills
- Relationships with the wider social system

Brief strategic family therapy should usually consist of fortnightly meetings over 3 months. It should focus on:

- Engaging and supporting the family
- Using the support of the wider social and educational system
- Identifying maladaptive family interactions
- Promoting new and more adaptive family interactions

Functional family therapy should be conducted over 3 months by health or social care staff. It should focus on improving interactions within the family, including:

- Engaging and motivating the family in treatment (enhancing perception that change is possible, positive reframing and establishing a positive alliance)
- Problem solving and behaviour change through parent training and communication training
- Promoting generalisation of change in specific behaviours to broader contexts, both within the family and the community (such as schools)

Multisystemic therapy should be provided over 3–6 months by a dedicated member of staff with a low caseload (typically between three and six cases). It should:

- Focus specifically on problem-solving approaches with the family
- Use the resources of peer groups, schools and the wider community

Interventions for Conditions Comorbid with Alcohol Misuse

For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, assess the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder (see the Depression: the treatment and management of depression in adults, NICE clinical guideline 90 [2009], and Generalised anxiety disorder and panic disorder [with or without agoraphobia] in adults: management in primary, secondary and community care, NICE clinical guideline 113 [2011]).

Refer people who misuse alcohol and have a significant comorbid mental health disorder, and those assessed to be at high risk of suicide, to a psychiatrist to make sure that effective assessment, treatment and risk-management plans are in place.

For the treatment of comorbid mental health disorders refer to the relevant NICE guideline for the particular disorder, and:

- For alcohol misuse comorbid with opioid misuse actively treat both conditions; take into account the increased risk of mortality with taking alcohol and opioids together (see Drug misuse: opioid detoxification, NICE clinical guideline 52 [2007], and Drug misuse: psychosocial interventions, NICE clinical guideline 51 [2007])

- For alcohol misuse comorbid with stimulant, cannabis (see the NGC summary of Drug misuse: psychosocial interventions , NICE clinical guideline 51 [2007]) or benzodiazepine misuse actively treat both conditions.

Service users who have been dependent on alcohol will need to be abstinent, or have very significantly reduced their drinking, to benefit from psychological interventions for comorbid mental health disorders.

For comorbid alcohol and nicotine dependence, encourage service users to stop smoking and refer to Brief interventions and referral for smoking cessation in primary care and other settings (NICE public health guidance 1).

Wernicke-Korsakoff Syndrome

Follow the recommendations in NICE clinical guideline 100 (Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications) on thiamine for people at high risk of developing, or with suspected, Wernicke's encephalopathy. In addition, offer parenteral thiamine followed by oral thiamine to prevent Wernicke-Korsakoff syndrome in people who are entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings and who are malnourished or at risk of malnourishment (for example, people who are homeless) or have decompensated liver disease.

For people with Wernicke-Korsakoff syndrome, offer long-term placement in:

- Supported independent living for those with mild cognitive impairment
- Supported 24-hour care for those with moderate or severe cognitive impairment

In both settings the environment should be adapted for people with cognitive impairment and support should be provided to help service users maintain abstinence from alcohol.

Clinical Algorithm(s)

The following are provided in the full version of the original guideline document:

- Care pathway: the case identification and possible diagnosis for adults (Figure 5)
- Care pathway: withdrawal assessment (Figure 6)

In addition, the Quick Reference Guide contains a care pathway for assisted alcohol withdrawal (see the "Availability of Companion Documents" field).

Scope

Disease/Condition(s)

Alcohol use disorders (alcohol misuse, harmful drinking, alcohol dependence)

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Hospitals

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To make recommendations for the treatment and management of alcohol dependence and harmful alcohol use
- To improve access and engagement with treatment and services for people who misuse alcohol
- To evaluate the role of specific psychological, psychosocial and pharmacological interventions in the treatment of alcohol dependence and harmful alcohol use
- To evaluate the role of psychological and psychosocial interventions in combination with pharmacological interventions in the treatment of alcohol dependence and harmful alcohol use
- To integrate the above to provide best-practice advice on the care of individuals throughout the course of their alcohol dependence and harmful alcohol use
- To promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service in England and Wales

Target Population

Adults and young people (aged 10–17 years) who are harmful drinkers or who have alcohol dependence

Interventions and Practices Considered

Diagnosis/Evaluation/Risk Assessment

1. Identification and assessment of alcohol misuse, including use of formal assessment tools
    - Alcohol Use Disorders Identification Test (AUDIT)
    - Severity of Alcohol Dependence Questionnaire (SADQ)
    - Leeds Dependence Questionnaire (LDQ)
    - Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar)

    - Alcohol Problems Questionnaire (APQ)
2. Assessment of alcohol misuse in specialist centres
    - Brief triage assessment
    - Comprehensive assessment
3. Referral of children and young people aged 10–15 years to a specialist child and adolescent mental health service (CAMHS) for a comprehensive assessment
4. Carrying out a motivational intervention as part of the initial assessment

Treatment/Management/Counseling

1. Use of appropriately trained and competent staff for delivering interventions
2. Building a trusting relationship and providing information to people who misuse alcohol
3. Encouraging families and carers to be involved in the treatment and care of people who misuse alcohol
4. Use of care coordination and case management
5. Use of community-based or specialist alcohol services (e.g., residential treatment)
6. Psychological interventions such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies, behavioural couples therapy
7. Benzodiazepines for assisted withdrawal (chlordiazepoxide or diazepam)
8. Pharmacological interventions such as acamprosate, naltrexone, disulfiram
9. Testing liver function, urea and electrolytes to assess for liver or renal impairment before starting disulfiram
10. Counselling users about the interactions between alcohol and disulfiram
11. Assessment and treatment of comorbid conditions such as depression and anxiety
12. Special considerations for management of children and young people who misuse alcohol
13. Use of thiamine in patients with Wernicke–Korsakoff syndrome

Major Outcomes Considered

- Rate of abstinence
- Relapse rate and time to relapse
- Alcohol consumption (amount) post-treatment
- Probability of hepatic disease or other liver complications
- Suicide rate
- Quality of life
- Cost-effectiveness of treatment
- Adverse effects of treatment

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

The Search Process (Clinical Evidence)

Scoping Searches

A broad preliminary search of the literature was undertaken in September 2008 to obtain an overview of the issues likely to be covered by the scope and to help define key areas. Searches were restricted to clinical guidelines, health technology assessment (HTA) reports, key systematic reviews and randomised control trials (RCTs), and conducted in the following databases and websites:

- British Medical Journal Clinical Evidence
- Canadian Medical Association (CMA) Infobase (Canadian guidelines)
- Clinical Policy and Practice Program of the New South Wales Department of Health (Australia)
- Clinical Practice Guidelines (Australian Guidelines)
- Cochrane Central Register of Controlled Trials (CENTRAL)
- Cochrane Database of Abstracts of Reviews of Effects (DARE)
- Cochrane Database of Systematic Reviews (CDSR)
- Excerpta Medica Database (EMBASE)
- Guidelines International Network (G-I-N)
- Health Evidence Bulletin Wales
- Health Management Information Consortium (HMIC)
- HTA database (technology assessments)
- Medical Literature Analysis and Retrieval System Online (MEDLINE)/MEDLINE in Process
- National Health and Medical Research Council (NHMRC)
- National Library for Health (NLH) Guidelines Finder
- New Zealand Guidelines Group
- National Health Service (NHS) Centre for Reviews and Dissemination (CRD)
- OmniMedicalSearch
- Scottish Intercollegiate Guidelines Network (SIGN)
- Turning Research Into Practice (TRIP)
- US Agency for Healthcare Research and Quality (AHRQ)
- Websites of NICE and the National Institute for Health Research (NIHR) HTA Programme for guidelines and HTAs in development.

Existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (AGREE Collaboration, 2003). The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate. Further information about this process can be found in The Guidelines Manual (2009).

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching, to maximise the retrieval of evidence to all parts of the guideline. Searches were restricted to: systematic reviews, meta-analyses, RCTs, observational studies, quasi-experimental studies and qualitative research. Searches were conducted in the following databases:

- Allied and Complementary Medicine Database (AMED)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- EMBASE
- MEDLINE/MEDLINE In-Process
- Psychological Information Database (PsycINFO)
- DARE
- CDSR
- CENTRAL
- HTA database

For standard mainstream bibliographic databases (AMED, CINAHL, EMBASE, MEDLINE and PsycINFO), search terms for alcohol dependence and harmful alcohol use were combined with study design filters for systematic reviews, RCTs and qualitative research. For searches generated in databases with collections of study designs at their focus (DARE, CDSR, CENTRAL and HTA), search terms for alcohol dependence and harmful alcohol use were used without a filter. The sensitivity of this approach was aimed at minimising the risk of overlooking

relevant publications, due to inaccurate or incomplete indexing of records, as well as potential weaknesses resulting from more focused search strategies (for example, for interventions).

For focused searches, terms for case management and assertive community treatment (ACT) were combined with terms for alcohol dependence and harmful alcohol use, and filters for observational and quasi-experimental studies.

Further details of the search strategies and filter used for the systematic review of health economic evidence are provided in Section 3.5.1 and Appendix 9 of the full version of the original guideline.

Study Selection and Quality Assessment

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time when they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (see Appendix 11 in the full version of the original guideline for methodology checklists). The eligibility of each study was confirmed by at least one member of the appropriate topic group.

For some review questions, it was necessary to prioritise the evidence with respect to the UK context (that is, external validity). To make this process explicit, the topic groups took into account the following factors when assessing the evidence:

- Participant factors (for example, gender, age and ethnicity)
- Provider factors (for example, model fidelity, the conditions under which the intervention was performed and the availability of experienced staff to undertake the procedure)
- Cultural factors (for example, differences in standard care and the welfare system).

It was the responsibility of each topic group to decide which prioritisation factors were relevant to each review question in light of the UK context. Any issues and discussions within topic groups were brought back to the wider GDG for further consideration.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess the quality of the data. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, the GDG did not accept evidence submitted as commercial in confidence. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Literature Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in September 2008 to obtain an overview of the issues likely to be covered by the scope and help define key areas. Searches were restricted to economic studies and HTA reports, and conducted in the following databases:

- EMBASE
- MEDLINE/MEDLINE In-Process
- HTA database (technology assessments)
- NHS Economic Evaluation Database (NHS EED)

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to economic studies and HTA reports, and conducted in the following databases:

- CINAHL
- EconLit
- EMBASE
- MEDLINE/MEDLINE In-Process
- PsycINFO

- HTA database (technology assessments)
- NHS EED

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period. For standard mainstream bibliographic databases (CINAHL, EMBASE, MEDLINE and PsycINFO), search terms on alcohol dependence and harmful alcohol use were combined with a search filter for health economic studies. For searches generated in topic-specific databases (HTA, NHS EED), search terms on alcohol dependence and harmful alcohol use were used without a filter. The sensitivity of this approach was aimed at minimising the risk of overlooking relevant publications, due to inaccurate or incomplete indexing of records on the databases, as well as potential weaknesses resulting from more focused search strategies (for example, for interventions).

Further details of the search strategies and filter used for the systematic review of health economic evidence are provided in Section 3.6.1 and Appendix 12 of the full version of the original guideline. Inclusion criteria are provided in Section 3.6.2 of the full version of the guideline.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Meta-Analysis

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

Data Extraction

Study characteristics and outcome data were extracted from all eligible studies that met the minimum quality criteria using a Microsoft Word-based form (see Appendix 11 of the full version of the original guideline document).

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were lost to follow-up, the data were excluded from the analysis (except for the outcome 'leaving the study early', in which case the denominator was the number randomised). Where possible, dichotomous efficacy outcomes were calculated on an intention-to-treat basis (that is, a 'once-randomised-always-analyse' basis). Where there was good evidence that those participants who ceased to engage in the study were likely to have an unfavourable outcome, early withdrawals were included in both the numerator and denominator. Adverse effects were entered into Review Manager, as reported by the study authors, because it is usually not possible to determine whether early withdrawals have had an unfavourable outcome.

Where there was limited data for a particular review, the 50% rule was not applied. In these circumstances the evidence was downgraded due to the risk of bias. Where some of the studies failed to report standard deviations (for a continuous outcome) and where an estimate of the variance could not be computed from other reported data or obtained from the study author, the following approach was taken.

When the number of studies with missing standard deviations was less than one third and when the total number of studies was at least ten, the pooled standard deviation was imputed (calculated from all the other studies in the same meta-analysis that used the same version of the outcome measure). In this case, the appropriateness of the imputation was made by comparing the standardised mean differences (SMDs) of those trials that had reported standard deviations against the hypothetical SMDs of the same trials based on the imputed standard deviations. If they converged, the meta-analytical results were considered to be reliable.

When the conditions above could not be met, standard deviations were taken from another related systematic review (if available). In this case, the results were considered to be less reliable.

The meta-analysis of survival data, such as time to any drinking episode, was based on log hazard ratios and standard errors. Since individual patient data were not available in included studies, hazard ratios and standard errors calculated from a Cox proportional hazard model were extracted. Where necessary, standard errors were calculated from confidence intervals (CIs) or p-value according to standard formulae (see Cochrane Handbook for Systematic Reviews of Interventions, 5.0.2, Higgins et al., 2009). Data were summarised using the generic inverse variance method, using Review Manager.

Consultation with another reviewer or members of the Guideline Development Group (GDG) was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer and cross-checked with the existing data set. Where possible, two independent reviewers extracted data from new studies. Where double data extraction was not possible, data extracted by one reviewer was checked by the second reviewer. Disagreements were resolved through discussion. Where consensus could not be reached, a third reviewer or GDG members resolved the disagreement. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

Synthesising the Evidence

Meta-analysis

Where possible, meta-analysis was used to synthesise the evidence using Review Manager. If necessary, reanalyses of the data or sub-analyses were used to answer review questions not addressed in the original studies or reviews.

Refer to section 3.5.3 of the full version of the original guideline for further discussion of meta-analysis methods used.

Publication Bias

Where there was sufficient data, reviewers intended to use funnel plots to explore the possibility of publication bias. Asymmetry of the plot would be taken to indicate possible publication bias and investigated further. However, due to a paucity of data, funnel plots could not be used.

Where necessary, an estimate of the proportion of eligible data that were missing (because some studies did not include all relevant outcomes) was calculated for each analysis.

Summary Statistics Used to Evaluate Assessment Instruments

The main outcomes that need to be extracted from diagnostic accuracy studies are sensitivity, specificity, positive predictive validity and negative predictive validity. These are discussed in detail in Section 3.5.4 of the full version of the original guideline document.

Presenting the Data to the Guideline Development Group

Study characteristics tables and, where appropriate, forest plots generated with Review Manager were presented to the GDG.

Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were included in the study characteristics table (and, where appropriate, in a narrative review).

Evidence Profile Tables

A Grading of Recommendations Assessment, Development and Evaluation (GRADE) evidence profile was used to summarise both the quality of the evidence and the results of the evidence synthesis. The GRADE approach is based on a sequential assessment of the quality of evidence followed by judgement about the balance between desirable and undesirable effects and subsequent decision about the strength of a recommendation.

For each outcome, quality may be reduced depending on the following factors:

- Study design (randomised trial, observational study, or any other evidence)

- Limitations (based on the quality of individual studies)
- Inconsistency
- Indirectness (that is, how closely the outcome measures, interventions and participants match those of interest)
- Imprecision (based on the CI around the effect size)

For observational studies the quality may be increased if there is a large effect, plausible confounding would have changed the effect, or there is evidence of a dose–response gradient (details would be provided under the other considerations column). Each evidence profile also included a summary of the findings: number of patients included in each group, an estimate of the magnitude of the effect and the overall quality of the evidence for each outcome.

Health Economics Methods

The aim of health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for alcohol misuse covered in the guideline. This was achieved by:

- A systematic literature review of existing economic evidence
- Decision-analytic economic modelling

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was undertaken in areas with likely major resource implications, where the current extent of uncertainty over cost effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with The Guidelines Manual (2009). Prioritisation of areas for economic modelling was a joint decision between the health economist and the GDG. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the GDG, the health economist and the other members of the technical team. The following economic questions were selected as key issues that were addressed by economic modelling:

1. What is the preferred method of medically-assisted withdrawal, in terms of clinical and cost effectiveness (taking into consideration the benefits/adverse effects) and for which people and in which setting (taking into account the nature of intervention in each setting)?
    - Community (taking into account levels of supervision: structured versus unstructured day programme)
    - Residential
    - Inpatient: mental health or acute hospital
    - Prisons
2. For people who are alcohol dependent or harmful drinkers, which pharmacological interventions aimed at attenuation of drinking/maintenance of abstinence are clinically and cost-effective?
3. For people who are alcohol dependent or harmful drinkers, which psychological and psychosocial interventions aimed at attenuation of drinking/maintenance of abstinence are clinically and cost-effective?
4. For people who are alcohol dependent or harmful drinkers, which combination of psychological/psychosocial and pharmacological interventions aimed at attenuation of drinking/maintenance of abstinence are clinically and cost-effective?

Applicability and Quality Criteria for Economic Studies

All economic papers eligible for inclusion were appraised for their applicability and quality using the methodology checklist for economic evaluations recommended by NICE (NICE, 2009a), which is shown in Appendix 13 of this guideline. The methodology checklist for economic evaluations was also applied to the economic models developed specifically for this guideline. All studies that fully or partially met the applicability and quality criteria described in the methodology checklist were considered during the guideline development process, along with the results of the economic modelling conducted specifically for this guideline.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Collaborating Centre for Mental Health on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version

of this guidance.

The Guideline Development Group (GDG)

The GDG consisted of: professionals in psychiatry, clinical psychology, nursing, social work, and general practice; academic experts in psychiatry and psychology; and service user, lay member and carer representatives. The guideline development process was supported by staff from the National Collaborating Centre for Mental Health (NCCMH), who undertook the clinical and health economic literature searches, reviewed and presented the evidence to the GDG, managed the process and contributed to drafting the guideline. Refer to the full version of the original guideline for additional information about the composition of the GDG.

GDG Meetings

Twelve GDG meetings were held between March 2009 and September 2010. During each day-long GDG meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GDG members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as part of a standing agenda.

Topic Group

The GDG divided its workload along clinically relevant lines to simplify the guideline development process, and GDG members formed smaller topic groups to undertake guideline work in that area of clinical practice. Topic group membership was decided after a discussion between all GDG members, and each topic group was chaired by a GDG member with expert knowledge of the topic area (one of the healthcare professionals). Topic Group 1 covered questions relating to pharmacological intervention. Topic Group 2 covered psychological and psychosocial interventions. Topic Group 3 covered assessment of alcohol misuse, Topic Group 4 covered service user and carer experiences of care, and Topic Group 5 covered delivery settings for treatment. These groups were designed to efficiently manage the large volume of evidence appraisal prior to presenting it to the GDG as a whole. Topic groups refined the review questions and the clinical definitions of treatment interventions, reviewed and prepared the evidence with the systematic reviewer before presenting it to the GDG as a whole, and helped the GDG to identify further expertise in the topic. Topic group leaders reported the status of the group's work as part of the standing agenda. They also introduced and led the GDG discussion of the evidence review for that topic and assisted the GDG Chair in drafting the section of the guideline relevant to the work of each topic group. All statements and recommendations in this guideline have been agreed by the whole GDG.

Integration of Other Guidelines on Alcohol-Use Disorders

In addition to this guideline, there are two other pieces of NICE guidance addressing alcohol-use disorders outlined in Chapter 1. During development, steering group meetings were held in which representatives from the three development groups met to discuss any issues, such as overlapping areas of review work and integration of the guidelines.

Review Questions

Review (clinical) questions were used to guide the identification and interrogation of the evidence base relevant to the topic of the guideline. The draft review questions were discussed by the GDG at the first few meetings and amended as necessary. Where appropriate, the questions were refined once the evidence had been searched and, where necessary, subquestions were generated. Questions submitted by stakeholders were also discussed by the GDG and the rationale for not including any questions was recorded in the minutes. The final list of review questions can be found in Appendix 7 of the full version of the original guideline.

For questions about interventions, the Patient, Intervention, Comparison and Outcome (PICO) framework was used (see Table 2 in the full version of the original guideline).

Questions relating to assessment and diagnosis do not involve an intervention designed to treat a particular condition, therefore the PICO framework was not used. Rather, the questions were designed to identify key issues specifically relevant to diagnostic tests, for example their accuracy, reliability and safety.

In some situations, the prognosis of a particular condition is of fundamental importance, over and above its general significance in relation to specific interventions. Areas where this is particularly likely to occur relate to assessment of risk, for example in terms of behaviour modification or screening and early intervention. In addition, review questions related to issues of service delivery are occasionally specified in the remit from the Department of Health/Welsh Assembly Government. In these cases, appropriate review questions were developed to be clear and concise.

To help facilitate the literature review, a note was made of the best study design type to answer each question. There are four main types of review question of relevance to NICE guidelines. These are listed in Table 3 of the full version of the original guideline. For each type of question the best primary study design varies, where 'best' is interpreted as 'least likely to give misleading answers to the question'.

However, in all cases a well-conducted systematic review (of the appropriate type of study) is likely to yield a better answer than a single study.

Deciding on the best design type to answer a specific review question does not mean that studies of different design types addressing the same question were discarded.

The GDG classified each review question into one of three groups: (1) questions concerning good practice; (2) questions likely to have little or no directly relevant evidence; and (3) questions likely to have a good evidence base. Questions concerning good practice were answered by the GDG using informal consensus. For questions that were unlikely to have a good evidence base, a brief descriptive review was initially undertaken and then the GDG used informal consensus to reach a decision (see below).

Forming the Clinical Summaries and Recommendations

Once the GRADE evidence profiles relating to a particular review question were completed, summary evidence tables were developed (these tables are presented in the evidence chapters of the full version of the original guideline). Finally, the systematic reviewer in conjunction with the topic group lead produced a clinical evidence summary.

After the GRADE profiles and clinical summaries were presented to the GDG, the associated recommendations were drafted. In making recommendations, the GDG took into account the trade-off between the benefits and downsides of treatment as well as other important factors, such as economic considerations, social value judgements, the requirements to prevent discrimination and to promote equality, and the group's awareness of practical issues.

Method Used to Answer a Review Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of appropriately designed, high-quality research, or where the GDG were of the opinion (on the basis of previous searches or their knowledge of the literature) that there were unlikely to be such evidence, an informal consensus process was adopted. This process focused on those questions that the GDG considered a priority.

Informal Consensus

The starting point for the process of informal consensus was that a member of the topic group identified, with help from the systematic reviewer, a narrative review that most directly addressed the review question. Where this was not possible, a brief review of the recent literature was initiated.

This existing narrative review or new review was used as a basis for beginning an iterative process to identify lower levels of evidence relevant to the review question and to lead to written statements for the guideline. The process involved a number of steps:

1. A description of what was known about the issues concerning the review question was written by one of the topic group members.
2. Evidence from the existing review or new review was then presented in narrative form to the GDG and further comments were sought about the evidence and its perceived relevance to the review question.
3. Based on the feedback from the GDG, additional information was sought and added to the information collected. This may include studies that did not directly address the review question but were thought to contain relevant data.
4. If, during the course of preparing the report, a significant body of primary-level studies (of appropriate design to answer the question) were identified, a full systematic review was done.
5. At this time, subject possibly to further reviews of the evidence, a series of statements that directly addressed the review question were developed.
6. Following this, on occasions and as deemed appropriate by the development group, the report was then sent to appointed experts outside of the GDG for peer review and comment. The information from this process was then fed back to the GDG for further discussion of the statements.
7. Recommendations were then developed and could also be sent for further external peer review.
8. After this final stage of comment, the statements and recommendations were again reviewed and agreed upon by the GDG.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

The economic evidence considered in the guideline is provided in the respective evidence chapters of the full version of the original guideline

document, following presentation of the relevant clinical evidence. The references to included studies and to those that were potentially relevant but did not meet the inclusion criteria can be found in Appendix 19 of the original guideline, as well as the evidence tables with the characteristics and results of economic studies included in the review. Methods and results of economic modelling undertaken alongside the guideline development process are presented in the relevant evidence chapters. Characteristics and results of all economic studies considered during the guideline development process (including modelling studies conducted for this guideline) are summarised in economic evidence profiles accompanying respective GRADE (Grading of Recommendations Assessment, Development and Evaluation) clinical evidence profiles in Appendix 18 of the full version of the original guideline document.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Registered stakeholders had an opportunity to comment on the draft guideline, which was posted on the National Institute for Health and Clinical Excellence (NICE) website during the consultation period. Following the consultation, all comments from stakeholders and others were responded to, and the guideline updated as appropriate. The Guideline Review Panel (GRP) also reviewed the guideline and checked that stakeholders' comments had been addressed.

Following the consultation period, the Guideline Development Group (GDG) finalised the recommendations and the National Collaborating Centre for Mental Health (NCCMH) produced the final documents. These were then submitted to NICE for the pre-publication check where stakeholders were given the opportunity to highlight factual errors. Any errors are corrected by the NCCMH, then the guideline is formally approved by NICE and issued as guidance to the National Health Service in England and Wales.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Improved access and engagement with treatment and services for people who misuse alcohol
- Appropriate identification and assessment of people who misuse alcohol
- Appropriate use of specific psychological, psychosocial and pharmacological interventions in the treatment of alcohol dependence and harmful alcohol use

Potential Harms

- Adverse effects of medically assisted alcohol withdrawal (e.g., seizures, delirium tremens, and hallucinations)
- *Acamprosate* is a well-tolerated medication with minimal side effects, contraindications or cautions associated with its use. The most common side effect is diarrhoea with abdominal pain, nausea, vomiting and pruritus also described.
- *Naltrexone* is also generally a well-tolerated medication with most trials reporting side effects similar to those reported with placebo or other drugs such as disulfiram or acamprosate. The most common side effects reported for naltrexone included nausea, headache, abdominal pain, reduced appetite and tiredness. Hepatotoxicity was reported in association with use of naltrexone to treat obesity when high doses (>300 mg per day) were used. Naltrexone should not be used in those with acute liver failure and caution is suggested when serum

aminotransferases are four to five times above normal. There is no consistent advice or evidence about monitoring of liver function tests for adverse effects on hepatic function. It is therefore important that the patient understands about the risk of hepatotoxicity and to stop taking naltrexone and promptly seek medical attention if they have any concerns about side effects or start to feel unwell. Deterioration in liver function tests or signs of liver failure have not been widely reported and increases generally normalise on stopping naltrexone.

- *Disulfiram*. Given the potential seriousness of the disulfiram–alcohol interaction in addition to the potential adverse effects of disulfiram alone, prescribing needs due care and consideration. Patients must be warned about and have capacity to understand the disulfiram-alcohol reaction and be made aware of the presence of alcohol in foodstuffs, perfumes, aerosols and so on. In addition, they should not have consumed alcohol for at least 24 hours before starting disulfiram and should also be warned that a reaction with alcohol may be experienced for up to 7 days after their last tablet. Fatal disulfiram–alcohol reactions have occurred with high doses of the drug (more than 1 g per day) and were associated with cardiovascular complications such as hypotension or corrected QT interval on the electrocardiograph. Caution is advised in the presence of renal failure, hepatic or respiratory disease, diabetes mellitus and epilepsy. Where reported, side effects of disulfiram alone and adverse events or reactions experienced include drowsiness, fatigue, abdominal pain, nausea and diarrhoea. Psychiatric problems such as dysphoria or psychosis were reported in some studies but the incidence was low. Neuropathy has been reported by some but not all studies, with onset commonly described over months to a year, although onset within days has also been described. Use of disulfiram may be associated with the development of an acute hepatitis, which can be fatal. The nature and exact incidence or prevalence of hepatotoxicity is unclear; however, it appears rare with, for example, 30 reports of hepatitis in the previous 40 years and 11 fatal liver reactions in 22 years (1968 to 1991). Given the seriousness of hepatitis, a role for monitoring of liver function has been suggested but there is limited evidence to inform guidance. It is therefore important that the patient understands about the risk of hepatotoxicity, and to stop taking disulfiram and promptly seek medical attention if they have any concerns about side effects or start to feel unwell. Psychiatric complications such as psychosis or confusional states are potentially serious side effects or adverse events and are more likely at higher doses (more than 500 mg per day).

For a full description of the side effects, contraindications and cautions, or interactions with other medications, prescribers must refer to the SPC or BNF.

Contraindications

Contraindications

- Contraindications to use of *acamprosate* include pregnancy and breastfeeding, renal insufficiency (serum creatinine >120 micromoles per litre) and severe hepatic failure (Childs-Pugh Classification C).
- Because it is an opioid antagonist, *naltrexone* cannot be used in people using opioid agonist drugs for analgesia. In addition, if analgesia is required in an emergency, nonopioid medication will be required because naltrexone blockade will last for 48 to 72 hours after taking the last tablet. Naltrexone should also not be used in those with acute liver failure.
- The summary of product characteristics (SPC) or British National Formulary (BNF) lists several significant medical and psychiatric contraindications to use of disulfiram, including cardiovascular problems, severe personality disorder, suicidal risk or psychosis, and contraindications to pregnancy and breast feeding.

Qualifying Statements

Qualifying Statements

- This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Implementation of the Guideline

Description of Implementation Strategy

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (see http://guidance.nice.org.uk/CG115 ; see also "Availability of Companion Documents" field).

Key Priorities for Implementation

Identification and Assessment in All Settings

- Staff working in services provided and funded by the National Health Service (NHS) who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need.

Assessment in Specialist Alcohol Services

- Consider a comprehensive assessment for all adults referred to specialist services who score more than 15 on the Alcohol Use Disorders Identification Test (AUDIT). A comprehensive assessment should assess multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:
    - Alcohol use, including:
        - Consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
        - Dependence (using, for example, Severity of Alcohol Dependence Questionnaire [SADQ] or Leeds Dependence Questionnaire [LDQ])
        - Alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
    - Other drug misuse, including over-the-counter medication
    - Physical health problems psychological and social problems
    - Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
    - Readiness and belief in ability to change

General Principles for All Interventions

- Consider offering interventions to promote abstinence and prevent relapse as part of an intensive structured community-based intervention for people with moderate and severe alcohol dependence who have:
    - Very limited social support (for example, they are living alone or have very little contact with family or friends) or
    - Complex physical or psychiatric comorbidities or
    - Not responded to initial community-based interventions
- All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff. Pharmacological interventions should be administered by specialist and competent staff (if a drug is used at a dose or for an application that does not have UK marketing authorisation, informed consent should be obtained and documented). Psychological interventions should be based on a relevant evidence-based treatment manual, which should guide the structure and duration of the intervention. Staff should consider using competence frameworks developed from the relevant treatment manuals and for all interventions should:
    - Receive regular supervision from individuals competent in both the intervention and supervision
    - Routinely use outcome measurements to make sure that the person who misuses alcohol is involved in reviewing the effectiveness of treatment
    - Engage in monitoring and evaluation of treatment adherence and practice competence, for example, by using video and audio tapes and external audit and scrutiny if appropriate

Interventions for Harmful Drinking and Mild Alcohol Dependence

- For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

Assessment for Assisted Alcohol Withdrawal

- For service users who typically drink over 15 units of alcohol per day, and/or who score 20 or more on the AUDIT, consider offering:
  - An assessment for and delivery of a community-based assisted withdrawal, or
  - Assessment and management in specialist alcohol services if there are safety concerns about a community-based assisted withdrawal

Interventions for Moderate and Severe Alcohol Dependence

- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone (at the time of publication [February 2011], oral naltrexone did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented) in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

Assessment and Interventions for Children and Young People Who Misuse Alcohol

- For children and young people aged 10–17 years who misuse alcohol offer:
  - Individual cognitive behavioural therapy for those with limited comorbidities and good social support
  - Multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support

Interventions for Conditions Comorbid with Alcohol Misuse

- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, assess the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder (see Depression: the treatment and management of depression in adults , NICE clinical guideline 90 [2009] and Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care, NICE clinical guideline 113 [2011]).

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. 54 p. (Clinical guideline; no. 115).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011 Feb

Guideline Developer(s)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group Members: Professor Colin Drummond (*Chair*), Professor of Addiction Psychiatry and Honorary Consultant Addiction Psychiatrist, National Addiction Centre, Institute of Psychiatry, King's College London, and South London and Maudsley Foundation NHS Trust; Professor Stephen Pilling (*Facilitator*), Director, National Collaborating Centre for Mental Health; Director, Centre for Outcomes Research and Effectiveness, University College London; Mr Adrian Brown, Alcohol Nurse Specialist, Addiction Services, Central and North West London NHS Foundation Trust, and St Mary's Hospital, Imperial College; Professor Alex Copello, Professor of Addiction Research, University of Birmingham, and Consultant Clinical Psychologist, Addiction Services, Birmingham & Solihull Mental Health Foundation NHS Trust; Dr Edward Day, Senior Lecturer and Consultant in Addiction Psychiatry, University of Birmingham/Birmingham & Solihull Mental Health NHS Foundation Trust; Mr John Dervan, Lay member and retired Alcohol Treatment Agency CEO; Mr Matthew Dyer, Health Economist, National Collaborating Centre for Mental Health (2008 to 2010); Ms Esther Flanagan, Guideline Development Manager, National Collaborating Centre for Mental Health (2008 to 2010); Ms Jan Fry, Carer representative and voluntary sector consultant; Mr Brendan Georgeson, Treatment Coordinator, Walsingham House, Bristol; Dr Eilish Gilvarry, Consultant Psychiatrist (with specialist interest in adolescent addictions), and Assistant Medical Director, Northumberland, Tyne & Wear NHS Foundation Trust; Ms Naomi Glover, Research Assistant, National Collaborating Centre for Mental Health (2010 to 2011); Ms Jayne Gosnall, Service User Representative and Treasurer of Salford Drug and Alcohol Forum; Dr Linda Harris, Clinical Director, Wakefield Integrated Substance Misuse Services and Director, RCGP Substance Misuse Unit; Dr John Lewis (Co-

opted specialist paediatric adviser), Consultant Community Paediatrician, Royal Cornwall Hospitals Trust; Professor Anne Lingford-Hughes, Professor of Addiction Biology, Imperial College London, Honorary Consultant, Central North West London NHS Foundation Trust; Dr Ifigeneia Mavranezouli, Senior Health Economist, National Collaborating Centre for Mental Health; Mr Trevor McCarthy, Independent Addictions Consultant and Trainer; Dr Marsha Morgan, Reader in Medicine and Honorary Consultant Physician, University of London Medical School; Mrs Stephenie Noble, Registered Manager/Nursing Manager, Broadway Lodge; Dr Suffiya Omarjee, Health Economist, National Collaborating Centre for Mental Health (2008 to 2010); Mr Tom Phillips, Consultant Nurse in Addiction, Humber NHS Foundation Trust; Dr Pamela Roberts, Consultant Clinical and Forensic Psychologist, Cardiff Addictions Unit; Mrs Kate Satrettin, Guideline Development Manager, National Collaborating Centre for Mental Health (2010 to 2011); Mr Rob Saunders, Research Assistant, National Collaborating Centre for Mental Health (2008 to 2010); Ms Laura Shields, Research Assistant, National Collaborating Centre for Mental Health (2009 to 2010); Dr Julia Sinclair, Senior Lecturer in Psychiatry, University of Southampton and Honorary Consultant in Addiction Psychiatry, Hampshire Partnership NHS Foundation Trust; Ms Sarah Stockton, Senior Information Scientist, National Collaborating Centre for Mental Health; Dr Clare Taylor, Senior Editor, National Collaborating Centre for Mental Health; Dr Amina Yesufu-Udechuku, Systematic Reviewer, National Collaborating Centre for Mental Health

Financial Disclosures/Conflicts of Interest

To minimise and manage any potential conflicts of interest, and to avoid any public concern that commercial or other financial interests have affected the work of the Guideline Development Group (GDG) and influenced guidance, members of the GDG must declare as a matter of public record any interests held by themselves or their families which fall under specified categories. These categories include any relationships they have with the healthcare industries, professional organisations and organisations for people with alcohol dependence and their families and carers.

Individuals invited to join the GDG were asked to declare their interests before being appointed. To allow the management of any potential conflicts of interest that might arise during the development of the guideline, GDG members were also asked to declare their interests at each GDG meeting throughout the guideline development process. The interests of all the members of the GDG are listed in Appendix 2 of the full version of the original guideline document, including interests declared prior to appointment and during the guideline development process.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .

Availability of Companion Documents

The following are available:

- Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. 245 p. (Clinical guideline; no. 115). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .
- Alcohol-use disorders. The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. Full guideline. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. 612 p. (Clinical guideline; no. 115). Electronic copies: Available in PDF from the NICE Web site .
- Alcohol-use disorders. The NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. Appendices. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. Various p. (Clinical guideline; no. 115). Electronic copies: Available in PDF from the NICE Web site .
- NICE pathways. Alcohol-use disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011. Various pages. Available from the NICE Web site .
- Alcohol use disorders: alcohol dependence. Costing report. London (UK): National Institute for Health and Clinical Excellence (NICE);

2011 Feb. 37 p. (Clinical guideline; no. 115). Electronic copies: Available in PDF from the NICE Web site.

- Alcohol use disorders: alcohol dependence. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. (Clinical guideline; no. 115). Electronic copies: Available from the NICE Web site.
- Alcohol dependence. Audit support. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Feb. (Clinical guideline; no. 115). Electronic copies: Available from the NICE Web site.
- Alcohol dependence and harmful alcohol use. Electronic audit tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 115). Electronic copies: Available from the NICE Web site.
- Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. Slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Aug. 34 p. (Clinical guideline; no. 115). Electronic copies: Available from the NICE Web site.
- Alcohol dependence. Baseline assessment tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 115). Electronic copies: Available from the NICE Web site.
- Alcohol use disorders: sample chlordiazepoxide dosing regimens for use in managing alcohol withdrawal. London (UK): National Institute for Health and Clinical Excellence (NICE); 2010 Feb. 24 p. (Clinical guideline; no. 115). Electronic copies: Available in PDF from the NICE Web site.
- Guide for commissioners: alcohol services. Available from the NICE Web site.
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. (Clinical guideline; no. 103). Electronic copies: Available in PDF from the NICE Archive Web site.

Patient Resources

The following is available:

- Alcohol dependence and harmful alcohol use. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2011 Feb. 16 p. (Clinical guideline; no. 115). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site. Also available in Welsh from the NICE Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on March 22, 2012. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

The National Institute for Health and Clinical Excellence (NICE) has granted the National Guideline Clearinghouse (NGC) permission to include summaries of their clinical guidelines with the intention of disseminating and facilitating the implementation of that guidance. NICE has not yet verified this content to confirm that it accurately reflects that original NICE guidance and therefore no guarantees are given by NICE in this regard. All NICE clinical guidelines are prepared in relation to the National Health Service in England and Wales. NICE has not been involved in the development or adaptation of NICE guidance for use in any other country. The full versions of all NICE guidance can be found at www.nice.org.uk.

Copyright Statement

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouseâ„¢ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion-criteria.aspx.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.